COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF RESPIRATORY CARE
250 WASHINGTON STREET, BOSTON, MA 02108
(617) 973-0800

APPLICATION FOR RESPIRATORY CARE LIMITED PERMIT
INSTRUCTIONS AND CHECKLIST

Carefully read the following instructions for completing the Limited Permit application.

General Information About the Application Process:

The Board of Respiratory Care ("Board") highly recommends that you refrain from accepting a Respiratory Therapist position in Massachusetts until you are licensed.

Once an application is received by the Board, it takes a **minimum of 3- 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested**. DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. **Incomplete applications will be returned to applicant.**

Complete applications must include the following documents:

☐ Completed application form, signed and dated by the applicant and notarized.

☐ 2x2 passport style color photo; white or off-white background; copies and printer generated photos are not acceptable.

☐ Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.

☐ Completed Verification of Education form.

☐ Request that the following documentation be sent to the above address:

> ☐ Transcripts from any post-secondary schools or programs that you have attended and/or completed/graduated or are currently attending. When requesting transcripts, please inform each school's registrar that the transcript must be complete and indicate the degree/certificate and date conferred in mm/dd/yyyy format [if applicable].

☐ Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdiction.

- **NOTE:** All documents must be received by the Board in signed, sealed envelopes.

☐ If you hold, or have ever held, any professional license or certification, you must request a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query and submit the Original report in a signed and sealed envelope with this application. To request a Self Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or http://www.npdb.hrsa.gov/. Keep a copy for your records.

- **NOTE:** If you do not hold and have never held any professional licenses in any other state or jurisdiction, you do not need to submit a National Practitioner Data Bank self-query.

☐ Check or money order payable to the Commonwealth of Massachusetts for $150.00. Cash or foreign currency is not accepted.

☐ Applications must be submitted on single-sided paper.

☐ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for a Respiratory Care Limited Permit are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

☐ Retain a copy of the completed application for licensure for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

IMPORTANT INFORMATION

A Respiratory Care Limited Permit applicant/holder must notify the Board in writing of any changes in the applicant's/permit holder's information within thirty (30) days of their occurrence, including but not limited to any change of address and any name change.

Pursuant to 261 CMR 2.08 (1), notwithstanding the expiration date stated on the Limited Permit, the privilege of practicing respiratory care pursuant to a Limited Permit shall automatically cease on the date a Limited Permit holder is no longer matriculated in and is not a graduate of a respiratory therapy program. Failure to achieve a passing score on the NBRC CCRT examination automatically voids a Limited Permit. In this event, you must cease all practice and notify the Board immediately. The Board will take appropriate action in response to any unlicensed practice.

An application is no longer valid if requirements for Respiratory Care Limited Permit are not met within one (1) year from the date of Board receipt. All fees are non-refundable and non-transferable.

The address of record is where the Board mails correspondence. Address changes may be done online at the Board's website www.mass.gov/dph/boards or you may obtain a form online to submit to the Board's office.

Retain a copy of the completed application for a Limited Permit for your records. Employers may require that you provide them with a copy.

Answers to many questions may be found on the Board's website (www.mass.gov/dph/boards). Statutes and regulations governing Respiratory Care Limited Permit holders may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.

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BOSTON, MA 02108
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RESPIRATORY CARE LIMITED PERMIT APPLICATION FEE - $150.00
ALL QUESTIONS MUST BE COMPLETED

1. APPLICANT NAME: _____
Last First Middle

a. MAIDEN/OTHER NAME: _____
(if applicable) Last First Middle

2. ADDRESS OF RECORD: _____
No. Street Apt. #

_____
City/Town State Zip Code

3. MOST RECENT PREVIOUS ADDRESS: _____
(Different to Address of Record) No. Street Apt. #

_____
City/Town State Zip Code

4. TELEPHONE NUMBER(S) Day: _____ Evening: _____ Cell: _____

5. _____/_____/_____ _____
Date of Birth (mm/dd/yyyy) **Place of Birth** (city/state/country)

HEIGHT: ____ Feet ____ Inches **WEIGHT**: _____ Lbs. **EYE COLOR**:_____

Sex: M F (Circle One) **MOTHER'S MAIDEN NAME**: _____

Email: _____

6. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):** _____/_____/_____
Pursuant to G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____ Receipt Number: _____

Limited Permit Number: _RL_____ Issue Date: _____Initials: _____

EDUCATION

7. RESPIRATORY CARE ACCREDITED DEGREE PROGRAM: _____
Program and Educational Institution

_____
No. Street City State Zip Code

Date Matriculated: _____ Anticipated Date of Graduation:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for an official transcript to be mailed directly to the Board by the degree-awarding institution.

8. OTHER POST-SECONDARY EDUCATION: _____
Name of Institution

_____
No. Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.

9. OTHER POST-SECONDARY EDUCATION: _____
Name of Institution

_____
No. Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.

10. OTHER POST-SECONDARY EDUCATION: _____
Name of Institution

_____
No. Street City State Zip Code

Degree Awarded: _____ Date Degree Awarded:_____/_____/_____
(mm/dd/yyyy)

Applicant must arrange for all official transcripts of other post-secondary education to be mailed directly to the Board by the degree-awarding institution.

VERIFICATION OF OTHER LICENSES/ BOARD CERTIFICATIONS

11. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS.

☐ I **DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.**

Issuing State/ Jurisdiction	Profession	License/Certification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board.

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

12. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

13. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

14. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

16. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $250 or less was imposed.

Yes ☐ No ☐

17. Have you ever been court martialed or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Respiratory Care any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Respiratory Care to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a limited permit to practice respiratory care, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a licensed respiratory therapist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for Limited Permit to practice Respiratory Care shall be deemed no longer valid if requirements for a Limited Permit are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Respiratory Care to deny issuance of a Limited Permit and to suspend or revoke a Limited Permit issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent passport photo (2x2)

NOTARY NAME**:** _____

COMMISSION EXPIRES: _____ [Seal]

INCLUDE A NONREFUNDABLE FEE OF $150.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

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VERIFICATION OF EDUCATION FORM
LIMITED PERMIT

Directions to Applicant: Complete the "APPLICANT SECTION" below and request that the Director of your respiratory therapy program complete and sign Page 3 of this form. Return the signed, completed form to the Board of Respiratory Care, 250 Washington Street, Boston, MA 02108. The Board will return a final, signed copy to you when your application has been approved.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within thirty (30) days of completion of additional competencies.

APPLICANT SECTION:

1. APPLICANT NAME: _____
Last First Middle

a. MAIDEN/OTHER NAME: _____
(if applicable) Last First Middle

2. ADDRESS OF RECORD: _____
No. Street Apt. #

_____
City/Town State Zip Code

3. Telephone Number(s) Day:_____ Evening:_____

4. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):** _____/_____/_____
Pursuant to G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

5. Program/School Name: _____

Address: _____
No. Street

_____
City/Town State Zip Code

Matriculation Date: _____
(mm/dd/yyyy)

I authorize the above named school to release the information requested on this form to the Board of Respiratory Care. I further authorize the Board to release information contained in this

section and to request pertinent additional information in connection with the processing of this application.

Signature of Applicant: _____ Date: _____
(mm/dd/yyyy)

DO NOT WRITE BELOW THIS LINE - FOR BOARD OF RESPIRATORY CARE USE ONLY

Date Received:
Permit Issue Date:
Expiration Date:
Permit # RL

THIS LIMITED PERMIT IS NOT VALID
WITHOUT BOARD SEAL

Based on the anticipated completion date of the program you are enrolled in, your Limited Permit expires on the date listed. The expiration date of a Limited Permit may be extended by the Board, as provided in 261 CMR 2.08.

A Limited Permit shall be valid during a student's matriculation in an accredited Respiratory Care education program. A Limited Permit shall **automatically** expire upon a student withdrawal or dismissal from an accredited Respiratory Care education program. Prior to the expiration of the limited permit, the Limited Permit holder must take and pass the CRT examination and provide official documentation of same to the Board, in completion of the full license application. Failure to achieve a passing score on the NBRC CCRT examination automatically voids the Limited Permit. In this case, you must cease practice and notify the Board immediately. The Board will take appropriate action in response to unlicensed practice.

A copy of the statute & regulations pertaining to Respiratory Care is available on the Board's web site at www.mass.gov/dph/boards or from the State House Bookstore, Room 116, State House, Boston, MA 02133. Phone: (617) 727-2834. The statutes for Respiratory Care are Massachusetts General Laws, Chapter 13, section 11B and Chapter 112, sections 23R through 23BB. The Board regulations are 261 Code of MA Regulations, sections 2.00 through 5.00.

[Board Seal]

VERIFICATION OF EDUCATION

PROGRAM SECTION: To be completed by Respiratory Therapy Program Director.
The individual named on this form has indicated that he/she is matriculated in the study of respiratory care in your program. Please complete this form and check "yes" or "no" for each of the respiratory care competencies the individual has successfully completed as of the date of this form.

NOTE: This form must be updated as additional competencies are achieved. Submit updated forms to the Board of Respiratory Care within thirty (30) days of completion.

Limited Permit Holder Applicant Name:

_____

Matriculation Date: _____/____/_____
(mm/dd/yyyy)

Type of Program (check one):___Master's ___ Bachelor's ___ Associate's ___ Certificate

NOTE: Applicant must be currently enrolled in a respiratory program to hold a limited permit.
Applicant is in his/her _____ year _____ semester of respiratory care study.

This individual will/has complete(d) the program on: _____/_____/_____.
(mm/dd/yyyy)

Respiratory Care Duties Successfully Completed: The applicant is eligible to perform specific procedures ONLY within the duties checked "yes". The applicant must also meet the educational program or employer's standards for these procedures in specified patient care situations.

	YES	NO
1. administration of medical gases	Y	N
2. use of gas administering devices	Y	N
3. administration of humidification and aerosols	Y	N
4. administration of aerosol medications	Y	N
5. support services for mechanically ventilated patients	Y	N
6. postural drainage	Y	N
7. bronchopulmonary hygiene	Y	N
8. breathing exercises	Y	N
9. respiratory rehabilitation	Y	N
10. cardiopulmonary resuscitation	Y	N
11. maintaining natural and artificial airways	Y	N
12. measuring ventilatory volumes, pressures, flows	Y	N
13. collecting specimens of blood and other materials	Y	N
14. pulmonary function testing	Y	N
15. hemodynamic and other related physiologic monitoring of the cardiopulmonary system	Y	N
16. teaching patients and families respiratory care procedures	Y	N
17. consultation for health educational and community agencies	Y	N
18. teaching knowledge, skills attitudes of respiratory care	Y	N

I certify that the individual named on this form has successfully completed the duties checked as "yes" and is in good academic standing in or a graduate of the program.

Program Director Name (Print): _____ [School
Program Director Signature: _____ Seal]
School Name: _____
Date: _____